Office of Quality Assurance (QA)
Division of Developmental Disabilities (DDD)
Status Report Form for Psychiatric Hospitalizations

The purpose of this form is to provide information relating to the admission of an individual with a developmental disability to a psychiatric hospital. Please fax this form, when completed, to the Office of Quality Assurance, DDD, at 462-1273. Thank you.

Name of Person Admitted:_____ Agency:_____
Name of person completing this form:_____ Date:_____

A. General Information

1. Date of recent hospitalization: _____Hospital:_____
2. Was emergency services contacted? ___No ___Yes
   Was a worker sent out? ___No ___Yes
3. What was the diagnosis of the person at the time of the admission? _____
   _____
   _____
4. What were the observable symptoms of the person prior to hospitalization?
   _____
   _____
   _____
   _____
   _____
5. Have there been any recent medication changes? ___No ___Yes (Describe:)_____
   _____
   _____
   _____
6. Does the person take their medications as prescribed? ___Yes ___No
7. Does the person have a current treatment plan? ___No ___Yes
8. Was the person compliant with his/her treatment plan? ___No ___Yes
9. Is the plan sufficient to meet his/her needs ___Yes ___No (Explain)_____
   _____
   _____
10. Does the person need a new plan or to have his/her plan amended? ___No ___Yes
11. Does the person see a professional (psychiatrist, psychologist, counselor, etc.) for treatment?
    ___No ___Yes (Specify name of person)_____
12. When was the person's last appointment with this professional? _____
13. How frequently (weekly, monthly, etc.) does the person see this professional?
    _____
14. Was the person's psychologist/psychiatrist contacted prior to this admission?
    ___No ___Yes
15. Does this person need a new treatment professional? ___No ___Yes
16. Does the person have a scheduled appointment with his/her treatment professional?
    ___No ___Yes (Date:)_____

17. Have there been any recent environmental, family, staff, work changes for the person?
___No ___Yes (Explain)_____
_____
_____

18. Who was notified about this incident? ___Family/Guardian ___DDD Social Caseworker
___Personal Care Physician ___Treatment Professional
___Other (Specify)_____

B. Prior History

18. When was the person's last psychiatric hospitalization? (Date:)_____
19. What were the treatment recommendations made at that discharge planning ?
_____
_____
_____
_____

20. What action was taken to implement these recommendations? _____
_____
_____
_____

C. Next Steps

21. What further action needs to be taken?
____ Service Plan Modifications ____ Follow up with Treatment Professional
____ Medication Changes ____ Environmental Changes
____ Assessment ____ Placement Change
____ Staff Training ____ Other (Specify:)_____
_____

D. Other

22. Any other relevant information:_____
_____
_____
_____

For Use by the Division of Developmental Disabilities and/or MHRH Only

Date of Receipt: _____ Date of Approval: _____

Reviewed, as necessary, by:

____ Office of Quality Assurance Staff Person: _____ Date: _____
____ Health Care Staff Person:_____ Date: _____
____ Incident Management Committee Administrator: _____ Date: _____

Any Further Action:
_____
_____

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